U.S. ARMY-BAYLOR UNIVERSITY

GRADUATE PROGRAM IN HEALTH CARE ADMINISTRATION

GRADUATE MANAGEMENT PROJECT:

A STUDY TO DESIGN AN OPTIMAL OUTPATIENT THIRD PARTY COLLECTION PROGRAM AT EISENHOWER ARMY MEDICAL CENTER

SUBMITTED TO LTC SADLON

IN PARTIAL FULFILLMENT

OF REQUIREMENTS FOR THE DEGREE

OF MASTER OF HEALTH CARE ADMINISTRATION

BY

CAPTAIN KENNETH R. HORNE, MS

FORT GORDON, GEORGIA

May 1994

REPORT DOCUMENTATION PAGE

Form Approved
OMB No. 0704-0188

1. AGENCY USE ONLY (Leave blank)	2. REPORT DATE	3. REPORT TYPE AND DATES COVERED
	MAY 1994	Final Report (07-93 TO 07-94)

4. TITLE AND SUBTITLE
A Study To Design An Optimal Outpatient Third Party Collection Program At Eisenhower Army Medical Center

5. FUNDING NUMBERS

6. AUTHOR(S)
CPT Kenneth R. Horne, MS

7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES)
Dwight David Eisenhower Army Medical Center
Fort Gordon, Georgia 30905

8. PERFORMING ORGANIZATION REPORT NUMBER
4a-94

9. SPONSORING/MONITORING AGENCY NAME(S) AND ADDRESS(ES)
U.S. Army-Baylor University Graduate Program in Health Care Administration
Academy of Health Sciences, U.S. Army (HSHA-MH)
Fort Sam Houston, TX 78234-6100

10. SPONSORING/MONITORING AGENCY REPORT NUMBER

11. SUPPLEMENTARY NOTES

12a. DISTRIBUTION/AVAILABILITY STATEMENT
APPROVED FOR PUBLIC RELEASE: DISTRIBUTION IS UNLIMITED

12b. DISTRIBUTION CODE

13. ABSTRACT (Maximum 200 words)

This study analyzed how the Outpatient Third Party Collection has functioned at Eisenhower Army Medical Center and focused on how the program can be improved. The author conducted a literature review using resources at the medical library at EAMC, the Medical College of Georgia, and other civilian institutions; interviewed several subject matter experts at EAMC and other medical centers; and analyzed historical and current data outlining the program's performance. Based on this research, the author developed a conceptual model which outlines the policies and procedures to be followed by all EAMC personnel involved in the program. Finally, the author presents key recommendations and conclusions on how the OTP collection program can be improved based on an overall analysis of this research project.

14. SUBJECT TERMS	15. NUMBER OF PAGES
Outpatient Third Party Collections; Third Party Collections; Health Insurance	88
	16. PRICE CODE

17. SECURITY CLASSIFICATION OF REPORT	18. SECURITY CLASSIFICATION OF THIS PAGE	19. SECURITY CLASSIFICATION OF ABSTRACT	20. LIMITATION OF ABSTRACT
N/A	N/A	N/A	UL

Acknowledgments

First, I thank my Lord and Savior Jesus Christ for giving me the strength and wisdom to complete this program. It has definitely challenged me for the past two years.

I thank my wife and best friend Toni for her constant support and understanding during this endeavor. She has been my foundation when times got hard and a very good listener.

I thank the Baylor University staff for providing me with the necessary skills needed to complete this GMP. In particular, I would thank Rene Pryor who assisted me in getting in the Baylor program and for being a good friend.

I would give special thanks to COL Earl B. Mally who has made my transition to the "TDA side of the house" especially rewarding. He is a superb mentor with a wealth of knowledge in healthcare who has allowed me the freedom to fully enjoy my residency year. He has played a significant role in the selection and completion of this GMP which will definitely be used to benefit this hospital.

I would like to thank all of the EAMC staff for their mentorship and instruction. In particular I am grateful to the entire Patient Administration Division Staff for their assistance in my research. I would also thank MAJ Stephen Wilkinson and MAJ Sam Franco (last year's

residents) for their guidance on numerous issues and for reading my paper. And, I can't forget MAJ Rosemary Kyte who was recently assigned to EAMC, and has since assisted me on numerous occassions with my GMP.

Last, but not least, I would like to thank my buddy Pete Dancy for going through this program with me and for coming with me to my residency. He has been a constant source of support during the past 2 years and I look forward to serving with him in the future.

Abstract

The study analyzed how the Outpatient Third Party (OTP) Collection Program has functioned at Eisenhower Army Medical Center and focused on how the program can be improved. The author conducted a literature review using resources at the medical library at EAMC, the Medical College of Georgia, and other civilian institutions; interviewed several subject matter experts at EAMC and other medical centers; and analyzed historical and current data outlining the program's performance.

Based on this research, the author developed a conceptual model which outlines the policies and procedures to be followed by all EAMC personnel involved in the program.

Finally, the author presents key recommendations and conclusions on how the OTP collection program can be improved based on an overall analysis of this research project.

TABLE OF CONTENTS

TABLE OF CONTENTS (CONT'D)

TABLE OF APPENDICES

LIST OF TABLES

A STUDY TO DESIGN AN OPTIMAL OUTPATIENT THIRD PARTY COLLECTION PROGRAM AT EISENHOWER ARMY MEDICAL CENTER

INTRODUCTION

Background Information

Eisenhower Army Medical Center (EAMC) is a 371-bed acute care facility which provides primary, secondary, and tertiary health care in medicine, surgery, psychiatry, clinical psychology, child/adolescent psychiatry, pediatrics, obstetrics and gynecology, and family practice.

EAMC remains dedicated to providing comprehensive, high quality medical services to it's beneficiary population. This population consists of active duty and retired military and their family members and totals over 90,000. As the southeast regional referral center, EAMC currently provides tertiary care for an estimated 1.5 million beneficiaries. These beneficiaries predominantly reside in Georgia, Kentucky, Alabama, South Carolina, Florida, Mississippi, and Puerto Rico. Approximately 40% of Eisenhower's inpatient workload is referred from outside of the catchment area.

The Department of Defense (DoD), has recently begun to define military medical benefits designed to ensure consistency in the benefit structure throughout the United

States consistent with the proposed American Health Security Act. The DoD has divided the Military Health Services Systems in the Continental United States into 12 different regions. EAMC has been designated as the Lead Agent for DoD Region III, which encompasses Georgia, South Carolina, and most of Florida. As a lead agent, EAMC is responsible for the development of a Tri-service health care delivery plan for DoD Region III(DoD OASD (HA), Nov 1993).

Conditions Which Prompted the Study

Historical Perspective

In 1986, Congress enacted Title 10, United States Code, Section 1095 as part of the Consolidated Omnibus Budget Reconciliation Act of 1985. Public Law 99-272, section 200(a)(1), drawn from this Act permits the Department of Defense (DOD) the right to collect from third party payers reasonable inpatient hospital care costs incurred on behalf of military retirees and family members. This legislation was based on the premise that there should be no difference between a military medical treatment facility (MTF) and a civilian medical facility in terms of reimbursement for medical services rendered (Federal Register, 1992).

The first few years of the Third Party Collection Program (TPCP) brought disappointment to Congress because

of the relatively low level of collections being made. In 1989, Congress amended the statute with Public Law 101-189, Section 727 to create an incentive for Uniformed Services to aggressively implement the program. This statute authorizes crediting monies collected under the TPCP to the appropriations account supporting the facility that provided the care. Department of Defense Instruction 6010.15 further stipulates that all funds collected under the TPCP, except for amounts used to finance collection activities, shall be used to enhance health care services (DODI 6010.15, 1993).

The scope of the Third Party Collection Program (TPCP) was expanded by section 713 of Public Law 101-511 in November 1990 by amending Title 10, U.S.C. 1095. This action significantly expanded the authority of DOD to collect from third party payers. This amendment gave DOD the right to collect from a family member or retiree's health insurance for both inpatient and outpatient care provided by the MTF.

TPCP at Eisenhower Army Medical Center

Eisenhower Army Medical Center has performed well in Third Party Collections. In FY 93, EAMC collected $4,873,353 under the Third Party Collection Program $4,248,060 from inpatient billings, $621,655 from outpatient billings and $3,638 from fraud collections.

Eisenhower began billing third party payers for

outpatient procedures in January 1992. Under very aggressive leadership, the Outpatient Third Party (OTP) Collection Program achieved an increase in collections from $111,400 in FY 92 to $621,655 in FY 93. During this time period, the OTP Collection Program has gone through many growing pains. This includes the implementation of a new information system, organizational structuring, and the development of patient encounter forms to capture billing information on patients seen in various outpatient clinics.

While the OTP Collection Program has made significant strides and achieved considerable results, the program has not realized its full potential. Historical data indicates that there were numerous unprocessed claims during the past fiscal year.
Additionally, there are future significant events such as DOD and Army health care reform initiatives and the implementation of an Electronic Data Interchange (EDI) system which could have a significant impact on this program in the future.

Also, during initial research efforts, the author contacted several Army and Air Force Medical Treatment Facilities (MTFs) to gain a better understanding of how their OTP Collection Programs were structured. The author was astonished to find that none of the facilities contacted could provide any type of Standing Operating

Procedure or policy which outlined their program. Most of the officials contacted stated that they were still in the process of developing their OTP Collection Programs because most of the attention in the past had been devoted to inpatient collections.

Therefore, the author views this time period as an excellent opportunity to study the OTP Collection Program here at EAMC from a current and retrospective view. This will result in the development of an optimal program to meet the goals of EAMC both today and in the future.

Information System Support for the OTP Collection Program

Eisenhower initiated a project in December 1991 to devise a method to handle the requirement to automate billing of the third party insurance companies for outpatient procedures. The project sponsor for this endeavor was the EAMC Information Management Division. The application user and operator responsibility was given to the Patient Administration Division.

U.S. Army Health Services Command directed that each medical activity was authorized to implement its OTP collection program with autonomy, and that all monies collected could be used by the facility to improve health care services. The Information Management Division reviewed several off-the-shelf products and found them to be limiting and expensive. It was determined that the basic functionality required could be developed in-house

at a significant savings to the medical center. After a series of meetings, funding was acquired, functionality defined, and an implementation plan was prepared. Oracle was selected as the database package due to its portability, availability, and use with current and projected DOD systems. The platform would be phased in as a stand-alone, microcomputer-based application and then migrated to a Novell local area network. The Information Management Division established the following major performance objectives for the program:

- To create an automated billing application which is simple to use and maintain to replace manual procedures.

- To speed the manual billing process by at least 50%.

- To allow easy extraction of management information for data analysis by clinic, procedure, and site.

- To minimize the disruption of the billing operation with the implementation of the new application.

- To take full advantage of data available through the Composite Health Care System (CHCS).

The application takes advantage of the automated patient database (CHCS) at the facility by accepting patient demographic, appointment, and insurance information already captured as a byproduct of normal operations. None of the current systems allow the automated capture of Current Procedural Terminology,

(CPT4) Codes information. Therefore, this information is matched to the patient record and entered directly into the OTP Collection Program application. Also, the description field in the International Classification of Diseases (ICD-9) Codes, in existing systems supports free form entry by the user. It does not support entry of this field by appointment/reception personnel making it a requirement for the OTP Collection Program application to directly accept this data. The system also allows manual entry should no automated patient appointing database exist at a given facility (EAMC, 1993).

Data is captured when a patient registers, makes an appointment, or presents for care by updating the existing database. When the patient encounter is completed, the physician completes the encounter form by checking the blocks for the appropriate CPT4 codes and ICD-9 diagnoses. The encounter forms are then gathered and taken to the OTP Collection Program billing office. The automated system creates a flat file of any day's appointments. The clerk in the billing office adds the CPT4 codes and ICD-9 diagnoses from the encounter form to the patient record and prepares the bill (UB-92).

Various reports can be produced at any time using any of the fields in the application and for any time period to show a mix of statistics. Standard reports are preformatted to show the total billed and collected for

any clinic, site, or to date. Electronic claims submission can be readily supported due to the flexibility of the application (EAMC, 1993).

Problem Question

How has the Outpatient Third Party Collection Program functioned at Eisenhower Army Medical Center and how should it be improved to meet the needs of our present environment and future?

Literature Review

Outpatient Care Trends

Outpatient care is defined as health services provided to patients who are not confined to a bed. It is the most common type of health service in the United States (Burns,1991). In recent years, outpatient care has grown tremendously at U.S. hospitals. Statistics compiled by the American Hospital Association demonstrate this trend. Between 1976 and 1990, outpatient visits at community hospitals increased more than 64 percent. This equates to 326 million visits per year. During the same period, the number of outpatient visits per 1,000 Blue Cross subscribers increased by 114 percent. Hospital-based ambulatory surgeries grew about 108 percent during the period from 1983-1989. This growth rate was fueled by a 57 percent increase in hospitals with

organized outpatient departments (Data Watch, 1991).

Hospitals are scrambling to determine the best way to administer outpatient programs, measure costs, and develop strategies in anticipation of a continued growth in ambulatory care throughout the decade. Hospital CEO's predict that outpatient services will account for nearly half of hospital's net patient revenues by the year 2000 (Anderson, 1992).

The growth in ambulatory care is spurred by a tremendous shift to outpatient surgery. This shift is prompted by pressures from third-party payers for hospitals to provide care in appropriate venues to reduce costs. Outpatient surgeries now equal or surpass the number of inpatient procedures performed at many hospitals (Anderson, 1991).

Health Insurance

Prior to the 1930's, responsibility for health care was primarily assumed by the individual person. Shortly after the depression, health insurance as we now know it came into being. Blue Cross and Blue Shield (BC/BS) emerged as a pioneer leader in the health insurance industry. Their major goal was to insure that hospitals and providers were paid for their services. This idea quickly caught on and numerous insurance companies emerged with similar coverage plans (Kongstevdt, 1989).

The most common forms of health care insurance today

are plans comparable to those provided by BC/BS or plans provided to an employee of an organization. Individual plans account for 15 percent of the policies in force while group plans comprise the remaining 85 percent (Jacobs, 1987).

President Clinton is committed to health care reform in this country and has recently stated the recommendations of the health care reform task force to the people of the United States. Under the proposed Clinton plan, every American will have universal health coverage with a basic health benefit package. This includes full insurance coverage for preventive services offered at an affordable price (Gaston, 1993).

Experts in the insurance industry such as Pat Rooney, a member of the Jackson Hole Group, agree that insurers are already heading in the direction that health care reform will likely push them. They are assuming a more active role with providers in an effort to erase some of the boundaries. Insurers are also generating more information to make the delivery of health care more efficient. These changes are demanded by the market, and any kind of "managed competition" must promote the same.

A new standard to insurers is likely to evolve, regardless of which plan is approved by the political process. Various plan proponents agree that insurers should no longer have the ability to risk-select, or

"cherry-pick" only healthy individuals. Insurance companies will have to abandon the old method of experience rating and now utilize a community rating methodology. This will radically change the way insurers have typically operated in the past. Enactment of this reform could leave only insurance companies that want to compete by managing cost (Hudson, 1993).

Bill Coding

All claims which are processed for reimbursement are sent to third party payers with medical service codes. These codes represent the diagnosis and medical procedure of the patient and in large part determine the amount of reimbursement from the third party payer.

CPT Codes

Current Procedural Terminology (CPT) Codes represent the medical procedure or service performed on the patient. The American Medical Association (AMA) publishes the Physicians' Current Procedural Terminology, Fourth Edition. This book provides a systematic listing and coding of procedures and services performed by physicians. Each procedure is identified by a five digit code which simplifies reporting. The CPT manual lists over 7,000 codes and is the standard for Medicare and the majority of third party payers (American Medical Association, 1993).

ICD-9 Codes

The International Classification of Diseases, 9th

Edition, lists codes for the diagnoses of diseases. These codes are used to facilitate the payment of health services, to evaluation utilization patterns, and to review the appropriateness of health care costs (Puckett, 1992).

The numerical code contains three to five digits with a decimal. By using five digits, a provider can code to a higher degree of specificity. When a CPT code does not match the ICD-9-CM code listed on the claim form, the procedure may be deemed medically unjustified. This may result in the denial of payment (Voorhees, 1992).

The Billing Process

In today's economic environment, the health care industry along with other businesses are seeking to maintain viability. To survive means that revenues must exceed expenditures. However, this task is becoming more difficult during an era of federal cuts, reimbursement restructuring, and an increasing uninsured population (Rizk, 1992).

The need to maximize reimbursement has caused physicians and health care institutions to more closely analyze their business practices. Emphasis is being placed on improving the billing process, accounts receivable, collections, and patient appointment scheduling. These functions are tracked to insure that there is an effective mechanism in place to secure a

consistent cash flow (Rizk, 1992).

With the rapid growth and expansion of computer hardware and software technology, automation has become a more viable alternative for many facilities. Vendors offer applications such as billing and accounts receivable, appointment scheduling, and electronic data interchange (Rizk, 1992).

Hospitals, insurers and the federal government are gearing up to process health care claims through the use of electronic data interchange (EDI). However, before implementing EDI, the following questions should be addressed:

- What data should be routinely collected?
- How will the data be used?
- What data should be exchanged, and under what circumstances?
- What are the best ways to structure the communications process?
- Who will bear the costs?

Although the EDI process is still evolving, most experts agree that information management departments will play a big role in its implementation. This is because widespread use of EDI would technologically involve a re-engineering of business processes throughout the hospital (Hard, 1992).

Some experts argue that the current process should

not be automated until the health care field redefines the claims process. Decisions on whether a payer will pay for a specific medical procedure should be known in advance based on electronic access to health benefits information. Therefore, the decision could be made before the claim was received so that the claim is simply a routine exchange of information (Anderson, 1992).

Total Quality Management

Total Quality Management (TQM) is a key philosophy used in this Graduate Management Project (GMP). The TQM philosophy of W. Edwards Deming emphasizes the message that organizations should constantly strive to improve the quality of their processes. TQM first made its mark in the industrial sector, but has quickly moved into service oriented organizations such as health care institutions.

Broadly stated, the TQM approach involves defining opportunities for improvement, identifying potential causes of problems, and taking actions to eliminate these causes. Process improvement focuses more on prevention rather than dealing with problems as they arise. The problem solving process is often applied throughout the health care facility on such processes as the patient billing system, nursing retention, quality of dietary services, and discharge planning, to name a few.

The principle of TQM in all areas of a hospital's operations requires total employee involvement. TQM

principles can be put into place when an employee sees an opportunity for improvement in the work area. Quality improvement teams, more commonly known as process action teams, composed of department directors, physicians, nurses, and other hospital personnel, come together to investigate how a particular process can be improved (Lynn, 1991).

Purpose

The purpose of this study is to develop a conceptual model of an Outpatient Third Party Collection Program which will serve as a benchmark for Eisenhower Army Medical Center and potentially for the Department of Defense. The objective is to maximize reimbursement for outpatient procedures from third party payers under the OTP Collection Program in the most effective manner possible. The unit of analysis for this study is the Outpatient Third Party Collection Program which is currently in existence at EAMC.

METHODS AND PROCEDURES

The author's primary objective in this project was to use the skills acquired during the didactic phase of the U.S. Army-Baylor University Program in Health Care Administration to improve the OTP Collection Program. This was accomplished by assisting other staff members

already involved in the process through research to help the program in achieving its highest potential. To obtain these results, the benchmark process was used to capture the best qualities of the EAMC OTP Collection program as well as other OTP Collection Programs throughout DOD. The following objectives were accomplished during this study:

The author conducted a literature review using the medical library at EAMC, the Fort Gordon Library, and resources at the Medical College of Georgia and Augusta College. The author also researched current policies on the program established by DOD and United States Army Medical Command. The purpose of this objective was to conduct an extensive review to determine current trends and developments in regard to third party collections for outpatient services.

The author interviewed several people who are directly involved with the program at EAMC. These people included the Chief, Patient Administration Division (C,PAD); the Chief, Resource Management Division (C,RMD); the Deputy Commander for Clinical Services (DCCS); the Deputy Commander for Administration (DCA), the project officer for OTP collections, numerous physicians, and receptionists. These interviews were conducted to understand how the EAMC program operates, how the program is performing, individual knowledge about the program, and individual perceptions about the program's strengths and

weaknesses. The author interviewed billing managers at University Hospital and the Medical College of Georgia. The author also interviewed TPCP managers at Walter Reed Army Medical Center, and Brooke Army Medical Center. The following questions were asked:

1. What are some of the common obstacles encountered by your program which keep you from maximizing collections?

2. What marketing strategies are used to inform patients and providers about your program?

3. What type of educational programs do you have in place to train personnel on your program?

4. Do you have a formal standing operating procedure or policy guideline in effect?

5. Does your program utilize electronic billing, and if so, how has it affected your program?

The author has served as a member of a committee which meets on a monthly basis to discuss third party collections at EAMC. This committee updates the Commander and serves as a forum where key staff involved with the program make recommendations on how the program can be improved. This forum was used to keep abreast of current issues in the program and served as a vehicle for the author to update the group on key findings discovered during the research process. The committee is structured and operates like a process action team (PAT). The author

conducted an analysis to determine how the program has functioned since its conception. Sub-tasks required to accomplish this task included the following:

- EAMC's OTP Collection Program performance data for FY 92, FY 93, and FY 94 was analyzed. Information included total outpatient visits, total encounters billed, total amount billed, and total amount collected.

- A computer assisted program entitled "Simple Case" was used to flowchart the EAMC OTP collection program at the context and detailed level. The author observed the process at six different clinics and at the OTP collection program office to verify the process.

- The author used methodology outlined in DODI 6010.15 to determine manpower requirements in accordance with U.S. Medical Command. This methodology uses claims processed annually by the MTF to determine staffing requirements. One full time equivalent employee (FTE) per 2,860 claims per year is used as the standard. The total number of claims processed is divided by 2,860 to determine the number of FTEs needed to perform outpatient billing (DODI 6010.15, 1993).

Based on the findings of this research, the author and PAD developed a conceptual model on how the program should be structured and administered at EAMC. This conceptual model was put into EAMC memorandum format, which is the approved method at EAMC used to establish policy and

procedures. This EAMC memorandum was then appropriately routed through key staff members directly affected by the memorandum. This action was accomplished in order to gain their approval and recommendations for changes before implementation of the new policy.

The author concluded this research by looking at two major issues which will have an impact on the EAMC OTP collection program in the immediate future.

The first issue looked at is the implementation of electronic data interchange (EDI). During this research process, EAMC was analyzing the feasibility of processing claims electronically. The author and the Chief, Information Management Division conducted a cost/benefit analysis on the feasibility of establishing EDI at EAMC. Current information in the literature about EDI, information obtained from Army MTFs already using EDI, and information regarding the cost of the proposed system was discussed in this study. This was accomplished to determine the potential effects of EDI on the EAMC in the future. Lastly, the author discussed how National and DoD Healthcare initiatives will impact the EAMC OTP collection program in the future.

Study Design

The author used a qualitative study design to research the OTP Collection Program at EAMC. The

qualitative findings of this research are presented in combination with some quantitative data generated by manpower analysis and cost data associated with the program. The author selected two primary references to aid in the conduct of the study design. These include Robert K. Yin's Case Study Research, Design and Methods, and Michael Q. Patton's Qualitative Evaluation and Research Methods. These references aided in the development of the study design, data collection efforts, and determination of validity and reliability of the GMP.

Validity and Reliability

The author used several principles to help deal with the problems of establishing the construct validity and reliability of this study. The first principle used was multiple sources of evidence. The author used information for this study collected from professional journals, DOD regulations, interviews, and direct observations of the EAMC program. Another principle used to enhance construct validity was to have the study reviewed by key participants and informants. The Deputy Commander for Administration, the Chief of the Information Management Office, and the Chief of the Patient Administration Division (PAD) were all solicited as reviewers of this study. This process provided valuable feedback and

recommendations on how this GMP could be improved prior to final submission.

Lastly, the author maintained a thorough chain of evidence during this study to increase the reliability of the information used. This principle allows an external observer to follow the derivation of any evidence from initial research questions to study conclusions. The author's preceptor was chosen to accomplish this task. The author also maintained a case study data base, consisting of informal notes, study documents, quantitative analysis, and all other forms of information generated during this study.

Ethical Issues

The ethical rights of people interviewed during this study were strictly preserved. This was accomplished by informing them of the purpose of this study and their right to refuse to answer any questions at any time. All privileged information provided to the author to include patient demographic data was considered confidential and was not released in the GMP.

RESULTS

Major Finding

The major finding of this study is that EAMC does not

have an approved documented systematic policy and procedure for the purpose of collecting outpatient third party monies.

It should be noted that EAMC PAD began drafting an OTP third party collection program Standing Operating Procedure (SOP) in the Summer of 1993. However, this SOP was never completed and approved. Portions of this SOP are being used by PAD and OTP collection program staff.

The author found that EAMC has an Outpatient Third Party Collection Program which has made significant strides since its implementation in 1992. The author attributes the success of this program directly to the EAMC Patient Administration Division Staff. This staff has aggressively implemented this program since its conception and has constantly searched for alternative ways to improve the program.

The continued and improved success of the EAMC OTP collection program is dependent upon a team effort. This includes complete support from the Commander down to the receptionists. During this study, the author determined that the EAMC OTP collection program does not have full support among all players throughout the institution. The author further determined that the EAMC program is somewhat fragmented with some staff and program players operating under slightly different procedures. This problem will be corrected with the implementation of a

Commander endorsed EAMC memorandum outlining the program's policies and procedures.

The Literature Review

The literature review was conducted at various institutions throughout Augusta, Georgia and yielded a great deal of information on billing for health services. However, the majority of information obtained was not as applicable to the military system as the author would have preferred. Regulations such as the Federal Register, and DODI 6010.15 were extremely helpful. The author located a particularly valuable resource which provides a weekly update on third party collections throughout Army MTFs. The Third Party Line, "Maximize Collections to Enhance Care", is published weekly by Mr. Doug Ashby, who is the Third Party Collection Program Manager for U.S. Army Medical Command. This resource provides information on current regulatory guidance, program trends, and lessons learned by MTFs throughout the Army.

Key points found in the literature included information on general financial management, medical coding, and the improvement of the billing process through automation and EDI.

The Interview Process

Interviews with the top management personnel directly involved with the OTP collection program proved to be

extremely rewarding. As a whole, these individuals were extremely knowledgeable with the current regulations governing the program. The Chief, Patient Administration Division is the backbone of the EAMC program. LTC Lewis Bandy has served as the Chief of Patient Administration for the past 5 years and directed the program through its infancy. He is extremely knowledgeable with the legislation governing the third party program and has a thorough understanding of the current regulations provided by U.S. Army Medical Command.

Interviews with insurance clerks and billing clerks revealed a lesser but adequate knowledge about the program. These individuals are very proficient in their individual responsibilities. However, they are less familiar with the conduct of the program and its goals as a whole. For example, there were several clerks who did not know what their clinic's status of collections to date was or their clinic's collection goal for the fiscal year.

The individual physician plays an extremely important role in the OTP collection program. The author found that overall, the average physician understands his primary responsibility in the program. This responsibility is to complete the patient encounter form which indicates the diagnosis of illness and any procedure performed on the patient. However, as with the clerk, a great deal of information in regard to the program's goals and current

status does not filter down to the individual physician. Thus, some physicians are not familiar with the program's goals and objectives.

The author interviewed the TPCP managers at Walter Reed Army Medical Center and Brooke Army Medical Center. While these interviews did familiarize the author more about third party collections, they did not yield any new or remarkable information.

Major feedback from the interviews as a whole indicated the following key information:

- A common obstacle is the failure to obtain a timely and accurately completed patient encounter form by the physician immediately after the encounter.
- Patients and individual providers are not kept informed about the program as a whole.
- Education of individuals involved with the program is accomplished primarily on an informal basis.
- Most MTFs do not have a standing operating procedure or formal written guideline outlining their program in effect.
- There are only two Army MTFs currently using EDI.

The interviews and observations of the billing process at University Hospital and the Medical College of Georgia produced information that the author expected. Both of these institutions devote a great deal of resources to their programs. Civilian hospitals rely on insurance

collections because their viability is significantly affected when collections are not made. Therefore, their motivation for profit is much higher than the military's. In short, dedication to collect monies from insurance companies receives the utmost attention and emphasis. Eisenhower third party collection staff reviewed the systems in place at these institutions prior to implementing their own system to gain a better understanding of what works best.

EAMC OTP Collection Program Committee

The author served as a member of the third party collection committee which meets on a monthly basis. This committee serves as an excellent vehicle to keep the top managers involved with the program abreast of current program trends, the status of collections, major problems and obstacles, and new regulatory guidance. The author views this committee as a excellent means to keep the program operating smoothly and efficiently. However, a deficiency in this committee is that it is not attended by personnel who are involved with the program at the user level. Also, there is no system in place to ensure that the information generated at these committee meetings is disseminated down to the individual physicians and clerks.

Examining the Program's Performance

An initial analysis of EAMC's performance for FY 93 showed that the program collected $621,655 during the

year. In comparison with other Army MTFs, EAMC ranked first. The following information provides data on the program's performance over the past three fiscal years:

TABLE 1
EAMC PROGRAM PERFORMANCE (FY92 - FY94)

FISCAL YEAR	OUTPATIENT VISITS	NUMBER BILLED	TOTAL COLLECTED
FY 92	595,971	Unknown	$111,400
FY 93	516,917	14,418	$621,655
FY 94 (AS OF 6 APRIL 1994)	226,909	11,086	$595,265

As previously mentioned, the program has made significant strides over the past two years. However, there are some indications that the program was not realizing its full potential in FY 93. The author looked at two different clinics which retrospectively billed for encounters at the clinic during FY 93. Depending on the insurance policy, healthcare institutions can backbill normally for a period of one year. There were two clinics which successfully backbilled for periods in FY 93. The nutrition care clinic was not actively involved in the OTP Collection Program during FY 93. However, the clinic backbilled for approximately 250 past encounters and received collections totaling approximately $13,000 dollars. The neurology clinic was actively involved in the OTP collection program in FY 93. However, this clinic

did miss numerous encounters which could have been successfully billed. The neurology clinic requested a raw encounter data printout from PAD for the last quarter of FY 93. This report provides the clinic information on patients with insurance who had encounters for a particular period, but were not billed. The clinic can then go back and determine which encounters can be successfully billed. For the period of July 1, 1993 to September 30, 1994, the neurology clinic identified 69 encounters which were missed. The clinic was able to successfully bill for these encounters producing substantial collections for the clinic. An exact dollar amount for these encounters could not be determined by the author. However, the point to be made is that there were significant numbers of encounters backbilled for only one quarter.

The author attempted to show more definitive information about missed encounters, however, many clinics do not keep accurate records on backbilling. The author was able to determine that missed encounters is a problem at different levels of severity among all clinics at EAMC. The author did a random sample of various clinics to determine how many encounters on patients with other health insurance seen in the clinics in FY 93 were not billed. Clinics such as Allergy, Cardiology, and Gastroenterology were analyzed. The author determined

that each one of these clinics missed at least 50 encounters during FY 93 for various reasons. These missed encounters have to be determined by looking at all encounters of persons with other health insurance which were not billed. Then, each encounter has to be analyzed to determine if it was billable. Therefore, the author stopped counting at fifty.

Billable encounters which are missed can be attributed to several variables. Obviously, the nutrition department was not actively billing in FY 93. Other reasons cited by PAD personnel, receptionists, and department chiefs include:

- Receptionists in some clinics do not always ask every patient, other than active duty, whether or not they have other health insurance.

- Patients do not always reveal the fact that they have other health insurance.

- Physicians in some clinics do not accurately complete the patient encounter form. Therefore, some encounter forms have to be returned to the clinic to be corrected and become lost.

The patient encounter form plays a very important role in the billing process. There were some indications of problems with the encounter forms which were discovered during this analysis. Because of this, the following key problem areas were analyzed:

- The author examined the number of encounter forms being returned to clinics because of inaccurate or missing information (Column 4, Table 2).

- The author examined the number of encounter forms that have to be medically coded after they reach the billing office.

- Lastly, the author looked at the total number of encounters out of the total number submitted that could actually be billed.

A random sample was taken of 12 different clinics during the period from 25 January 1994 to 17 February 1994. An analysis of the problem areas stated above was conducted to determine if there were any trends or similar problems among different clinics.

The following data was compiled during this random sample:

TABLE 2
PATIENT ENCOUNTERS FROM 12 CLINICS
25 JANUARY TO 17 FEBRUARY 1994

CLINIC/ SERVICE	TOTAL ENCOUNTERS RECEIVED BY PAD	TOTAL BILLABLE ENCOUNTERS RECEIVED	TOTAL ENCOUNTERS RETURNED FOR CORRECTION	TOTAL ENCOUNTERS NEEDING CODING
INTERNAL MEDICINE	765	209(27%)	10(5%)	28(13%)
ORTHOPEDICS	93	44(47%)	4(9%)	18(41%)
FAMILY PRACTICE	763	355(46%)	22(6%)	121(34%)
CARDIOLOGY	680	228(33%)	38(17%)	107(47%)
EMERGENCY ROOM	255	175(69%)	17(10%)	68(39%)
PRIMARY CARE	357	127(35%)	28(22%)	44(35%)
NEUROLOGY	129	56(43%)	10(6%)	0
GENERAL SURGERY	60	45(75%)	2(4%)	5(11%)
OB/GYN	120	59(49%)	5(8%)	9(15%)
OTOLARYN-GOLOGY	69	20(29%)	13(6%)	8(4%)
OPTHAMOLOGY	66	27(41%)	4(15%)	4(15%)
HEM/ONC	53	20(38%)	0	4(2%)
TOTAL	3,410	1,365(40%)	153(11%)	416(30%)

This information indicates three separate problems. They are as follows:

- Some clinics are submitting encounter forms on all patients. Current guidance requires encounter forms to only be submitted on patients with other health insurance. Only 40 percent of the encounters received during this

time period were submitted on patients with other health insurance. The other encounter forms were useless.

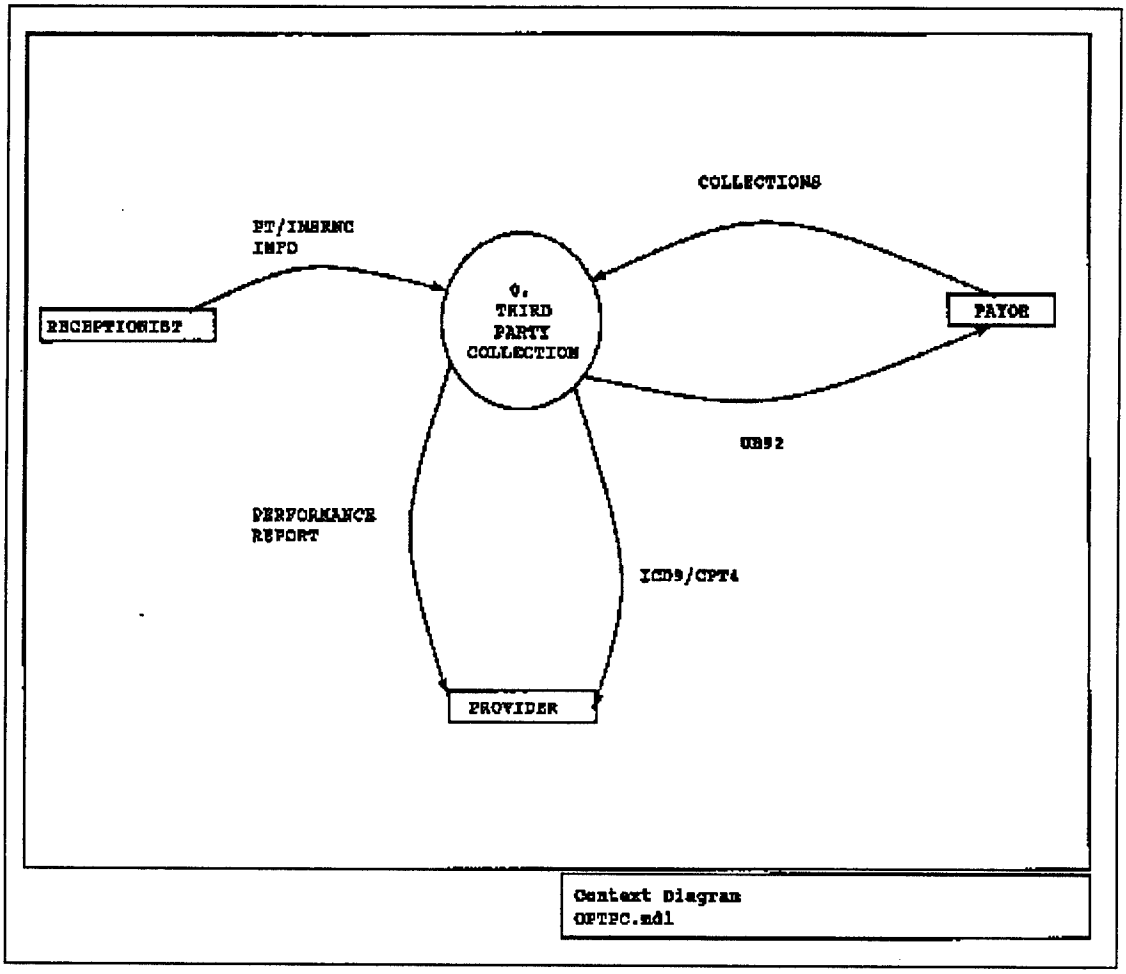
- A total of 416 (30%) encounters received required coding once they reached the OTP collection program billing office. Patient encounter forms require coding when the physician has to write in the diagnoses or procedure performed on the patient. This indicates that some encounter forms may have to be updated to reduce the number of coding requirements at the billing office.

- A total of 153 (11%) encounter forms were returned for correction. This indicates that there are some physicians who are not complying with their responsibility and/or are not familiar with the proper way to complete the patient encounter form.

Flowcharting the System

The EAMC OTP collection program was flowcharted and analyzed for bottlenecks and unnecessary redundancy. The author found the process to be well designed and simple to understand. The context diagram showing the basic flow is as follows:

FIGURE 1



In an effort to further analyze the internal processes which occur during the OTP collection program, the basic flowchart was expanded to view the internal processes. A diagram was constructed to further clarify the entire system (See Appendix D):

The author observed the OTP collection program process

at six different clinics. The author's major finding is that some clinics are not following this process. Some clinics conduct their programs a little differently. Other common problems observed by the author during these clinic observations were as follows:

- Some physicians are not knowledgeable about the OTP collection program.

- Patient encounter forms are not updated on a routine basis.

- Physicians and receptionists are not aware of the current status and major issues going on in the program.

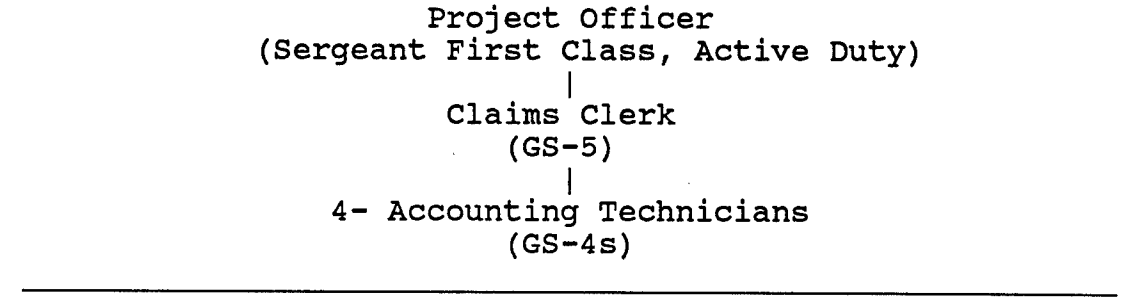
- There is a lack of motivation in some departments to support the program.

- Some clinics experience difficulty when their insurance clerks or receptionists are absent for extended periods of time because of illness or leave.

Manpower Requirements

The EAMC OTP outpatient billing office is currently structured as follows:

FIGURE 2



In accordance with the methodology outlined in DODI 6010.15, the author found this organizational structure to be adequate to administer the current program at EAMC. One FTE per 2,860 claims per year is the established standard. During FY 93, EAMC processed 14,418 claims. This equates to a requirement of five FTEs required to administer the EAMC program.

Implementing EDI at EAMC

The author and the Chief of the Information Management Division conducted a cost/benefit analysis to determine the feasibility of implementing EDI at EAMC. It was concluded by this analysis that it would be feasible to implement EDI into the OTP collection program. A cost/benefit analysis revealed the following:

TABLE 3

Program Costs:

NEIC EDI Service Costs: $5,000 (outpatient)

Savings (per bill):

First Class Postage:	$.029
UB 92 (Claim Form) :	$.0404
Envelope:	$.04
	$.3704

FY 94 (Estimate) 30,000 bills (Based on current mid-year data).

45% of bills will be electronically processed by NEIC

Savings For FY94: $.3704 * (30,000 * 0.45) = $5,000.40

Cost per bill using EDI: $.3703

There are no significant differences in costs during the first year's use of EDI. However, there are numerous intangible benefits to be gained which are outlined in the discussion paragraph. Additionally, costs for EDI services decrease in subsequent years to $3,200 per year.

The Future of the OTP Collection Program:

The healthcare system in the United States has generated a tremendous amount of attention over the past years. The White House Healthcare Reform Task Force has recently completed an endeavor to design a new healthcare delivery system. The recommendations of the task force have now entered the congressional debate phase. During this phase, the plan will be analyzed and reviewed in an effort to have some plan passed by legislators in the future. Unfortunately, no one knows how long this process will take.

The author attempted to determine how this initiative as well as DoD healthcare reform initiatives will affect the EAMC OTP collection program in the near future (five years). While there is a lot of speculation as to the fate of the program, the author could not draw any definitive conclusions about any significant changes to the program over the next 5 years. Interviews were conducted with lead agent personnel working on the request for proposal (RFP) to select a managed care contractor for DoD Region 3. Results from these interviews indicate that

there are no proposals to change the OTP collection program from its current format.

The author has determined that the OTP collection program does have the potential to improve and maximize third party collections in the coming years. This program should continue to thrive until its fate is determined in the future.

DISCUSSION

Major Finding

Interviews with people who have been involved with the OTP collection program since its conception indicate that the program has always had strong support from the EAMC Commander. The author previously stated that the program can also attribute a large portion of its success to the PAD staff. As with any other Army MTF, EAMC can expect a turnover in personnel on a routine basis. However, over the past five years, the TPCP has enjoyed a steady constant in the Chief of PAD. Also, the key Noncommissioned Officers (NCOs) involved with the program have been at EAMC for the past five years. These individuals possess a wealth of information on the program and have served as advisors to other MTFs throughout the United States. However, a good program cannot rest on its laurels. The Chief of PAD will be retiring from the military in the summer of 1994, and the Medical Center

received a new Commander in December 1993. It is imperative that the program's policies and procedures be approved and documented in memorandum format. This memorandum will establish responsibilities for the program among all players involved.

The Interview Process

One of the author's key objectives in conducting interviews with the Chief of PAD and other OTP collection program employees was to identify the need for education. The top management personnel proved to be very knowledgeable with the program. However, interviews with insurance clerks, receptionists, and physicians revealed a distinct difference in knowledge. These individuals are the key players in the program and have to be kept informed of what is going on. Another problem is that new personnel assigned to EAMC are often not educated on the OTP collection program after their arrival. One clinic experienced severe difficulties upon the arrival of a new Noncommissioned Officer in Charge. For a period of time, this clinic did not process encounter forms on patients. The PAD staff had to manage this clinic and reindoctrinate them to their responsibilities in the OTP collection program.

It is obvious that these incidents could be precluded if an approved written policy is established outlining

responsibilities for the program. Included in this memorandum will be guidance on how new personnel will be educated and how personnel involved with the program will be kept abreast of its status.

Augusta, Georgia has a large number of healthcare institutions who rely on collections from insurance for their viability. Therefore, institutions like the Medical College of Georgia and University Hospital are constantly searching for ways to improve their programs. EAMC has improved communications with these organizations over the past two years. During the OTP collection program's infancy, both of these institutions were visited by EAMC to gain insight on how their insurance billing offices operate. EAMC would continue to benefit by observing these institution's billing process as a benchmark to continually improve the EAMC program.

EAMC OTP Collection Program Committee

The heart of W. Edward Deming's message of Total Quality Management (TQM) is that organizations should strive to constantly improve the quality of their systems or processes. Process improvement focuses on prevention rather than reacting to errors or complaints as they arise. Deming's process improvement approach involves defining opportunities for improvement, identifying potential causes of problems, and taking action to eliminate these causes(Lynn, 1991).

The EAMC TPCP committee is devoted to improving the program process. This committee routinely meets on a monthly basis to discuss issues which typically cause problems with the program. However, this committee is normally attended only by top managers such as the EAMC Commander, DCA, Chief of PAD, Chief of RMD, Chief of IMD, and other TPCP managers. The people who conduct the day-to-day business of talking with beneficiaries, gathering other health insurance information, and billing third party payers are likely to be the first to recognize the need for process improvements. A formal issues process will ensure that new ideas achieve visibility and consideration (DODI 6010.15, 1993). Therefore, these people should be given the opportunity to attend the monthly committee meeting or submit a formal recommendation to make suggestions on how the program can be improved (See Appendix E).

Examining the Program's Performance

The author's analysis of EAMC's performance for FY 93 indicated that the program is ranked first among all other Army MTFs. Further analysis also indicated that the program has the potential of improving and further maximizing third party collections. The author has identified key areas involving the OTP collection process requiring further discussion. They include the patient encounter form, education, marketing, and the development

of a conceptual model outlining the policies and procedures for the administration of the program.

The Patient Encounter Form

The patient encounter form is central to the OTP collection program. This form is important when it comes to the coding and billing process. The patient encounter form has been used extensively for the past ten years. It is used to accurately record the services and procedures provided by healthcare institutions (Davis, 1992).

A well designed patient encounter form can make a significant difference in third party collections. When the OTP collection program at EAMC began, extensive research was conducted by PAD on the design of the EAMC patient encounter forms. Healthcare institutions such as the Medical College of Georgia and University Hospital were visited to gain insight on the design of the forms. The end product resulted in patient encounter forms for each clinic participating in the OTP collection program which were stored on a computer to facilitate easy updates.

During research, the author determined that some of the patient encounter forms have not been updated on a routine basis. Information compiled in the results section of this GMP clearly supports this because there is an increasing number of patient encounter forms needing medical coding once they reach the OTP collection program

billing office. This occurs when a patient encounter form does not have the diagnosis or procedure performed in the clinic on the form. This forces the physician to write in the diagnosis and procedure performed on the patient. Often, the physician does not use standardized terminology, so the patient encounter form has to be returned to the clinic for verification. This can result in delayed time in billing and lost encounter forms.

The author also determined during the interview process that there is some confusion as to who is responsible for updating the patient encounter form. Some physicians feel that this is an administrative responsibility. It has been included in the new EAMC policy that the Department Chiefs are responsible for the prompt revision of all patient encounter forms on a routine basis. These forms should be updated to reflect current CPT-4 codes and appropriate procedures, tests, and diagnoses for each clinic. The Department of Family Practice has recently done an excellent job of updating their patient encounter form (See Appendix B, p. B-6). Other clinics should strive to ensure that their encounter forms are updated and that physicians are educated on the encounter form in general. These actions will result in the timely and accurate submission of bills for services provided by the clinic.

OTP Collection Program Education

The Patient Administration Division has performed a good job of monitoring the need for education in regard to the OTP collection program. This action is accomplished primarily by the Chief of PAD, the project NCO, and other PAD staff who look for indicators of problem areas in the program. The project NCO also visits each clinic at least twice weekly and talks with the Clinic NCOs.

There is a need to continually improve the educational efforts for the program down at the user level. The author noted the following during clinic observations of the program:

- There is a difference among some clerks in terms of the way patients are greeted (customer courtesy)

- Personnel involved in the program do not possess guidelines or operating procedures defining their responsibilities.

- Some healthcare providers don't feel that they have the time or incentive to complete the patient encounter forms in a timely and accurate manner.

The Patient Administration Division has conducted two major training events for the OTP collection program during this research project. The first training event was a TPCP conference which was attended primarily by representatives from MTFs throughout the EAMC region. The second training event was provided primarily to EAMC

personnel to assist them with problem areas noted with the program. Neither one of these training seminars was mandatory for EAMC third party collection program personnel. Attendance was fair. There needs to be more Command emphasis requiring attendance at these excellent educational opportunities.

The author and PAD have made an effort to improve program education and awareness by developing a newsletter which will be published in the near future. This newsletter will provide information on issues such as the program's status, new regulations and policy, and educational opportunities to name a few (See Appendix B, p. B-8). It should also be noted that third party collections has now been included on the routine agenda for various meetings and committees.

There are some Departments such as Family Practice and Surgery that have conducted grand rounds and in-services on third party collections. Other clinics need to place as much emphasis on ensuring that their physicians and clinic personnel are well educated on the OTP collection program. Also, Department Chiefs and Department Healthcare Administrators should more actively collaborate their lessons learned to each other in regard to third party collections.

Marketing the OTP Collection Program

As the budget for healthcare continues to decline,

the TPCP is becoming more and more important as a method to supplement the EAMC budget. Therefore, a strong marketing program for both the OTP collection program staff and patients is vitally important. There have been some very aggressive efforts to advertise and educate beneficiaries about third party collections and its significance. This was accomplished by articles written in the local and post newspaper and by posting signs and passing out brochures to patients in the clinics. During this research project, the author has seen a decline in these marketing efforts. Many clinics do not post signs about the program anymore and patient brochures are sparsely scattered throughout the clinics.

The latest EAMC marketing effort has been directed primarily to the EAMC staff. The EAMC OTP collection program incentive program was recently established. This program was developed by first developing collection goals (baselines) for clinics to meet based on FY 93 historical data (See Appendix C). It was determined that respective departments would be able to keep 50 percent of all monies collected above their baseline. This money can be used at the department's discretion for things such as new equipment and medical education conferences. This new incentive program has resulted in new zeal and interest in the program.

The "Third Party Line" has often given various tips

on how the third party collection program should be marketed at MTFs (Ashby, 15 Oct 93). Some of the tips are as follows:

- Offer performance incentives to TPCP personnel such as 3 and 4 day passes for military, and cash awards for civilians.

- Produce TPCP marketing brochures answering frequently asked questions about the program and make them available at each clinic and the information desk (Appendix F).

- Consider a mass mailing of DD Forms 2569, Third Party Collection Program Insurance Information, to all known nonactive duty beneficiaries in the catchment area.

- Place labels on equipment purchased with TPCP funds. Insure that they are as visible as possible to staff and patients (Appendix G).

- Educate beneficiaries at events such as retiree activity day and/or a registration open house.

It should be noted that some clinics have used some of the above tips such as providing performance incentives for their employees. However, all clinics as a whole need to become more aggressive in marketing the program to patients and staff. Several marketing suggestions have been included in the new EAMC policy memorandum.

Development of the Conceptual Model

A conceptual model was developed by the author and

PAD to establish responsibilities and procedures for the collection of monies under the OTP collection program. The author reviewed a draft standing operating procedure which was developed by EAMC PAD in the summer of 1993. The author reviewed a newly written policy developed by Walter Reed Army Medical Center on its program. The author also reviewed policies developed by the billing offices of the Medical College of Georgia and University Hospital. Based on observations of these documents, and through this research, a conceptual model was developed on how the EAMC program should be administered (See Appendix B). This new EAMC memorandum should be reviewed on an annual basis to ensure that the regulation adequately describes desired policies and guidance for the program.

Electronic Data Interchange

Two of the key principles embodied in President Clinton's Health Security Plan are simplicity and savings. The president's plan strongly endorses the use of standard paper forms as well as the development of national standards for electronic transactions. The Workgroup for Electronic Data Interchange (WEDI) was formed in late 1991 by then Secretary of Health and Human Services, Louis Sullivan, M.D. The WEDI Steering Committee membership consists of 26 national organizations representing providers, payers, consumers, federal and state healthcare

government agencies and businesses. The WEDI has been actively involved analyzing the cost/benefits of Electronic Data Interchange (EDI). Preliminary data from WEDI indicates that EDI has the potential to become one of the most significant cost savers within the Clinton healthcare reform plan. Potential benefits include administrative cost savings, quality improvement, and improved cost effectiveness of healthcare services (Schnaich, 1993).

In December 1992, it was mentioned at the Triservice Third Party Collection Program conference that electronic billing is the wave of the future. The MEDDAC at Ft. Eustis took the initiative and became the first Army MTF to implement and process its bills electronically. As a result, the majority of their claims are collected within 21 days. Ft. Eustis reports several advantages to electronic billing over mailing bills to third party payers. They include:

- Significantly reduced turnaround time, which speeds up cash flow and reduces aging of accounts.

- Increased capability to track the status of bills which is useful in preventing invalid denials through expeditious problem resolution.

- And, the capability to use the host data base to determine who is covered under a specific policy, and what services they are covered for (Ashby, 14 May 1993).

In early 1994, Brooke Army Medical Center (BAMC) began sending their inpatient and outpatient bills electronically. BAMC made the decision to contract with National Hospital Systems (NHS) to provide this service. BAMC reported the following advantages to its program:

- Decreased turnaround time. Many payments are received within 5 days of billing.

- Decreased dependence on the availability of billing forms. The system automatically converts it to the required form.

- And, decreased phone time. The status of bills can be quickly checked electronically, and the insurance company cannot "lose the bill" (Ashby, 4 Feb 94).

Late in 1993, the EAMC third party collection team began looking into electronic billing. After a great deal of research, EAMC decided to consider using the National Electronic Information Corporation (NEIC) to provide this service. NEIC is the nation's largest electronic health claims clearinghouse linking healthcare providers and insurance payers together. NEIC initiates this connection by electronically receiving claim information from providers or healthcare billing service vendors. The NEIC system then edits claims for completeness, logic and proper format. If errors are found, NEIC highlights them through a "guided tour" system. Defining the problem is eliminated since an explanation for each field in error

allows for on the spot editing. Reports generated by NEIC identify both clerical errors and missing information. The medical claim processing systems allow for rejected claims to be corrected and retransmitted to the appropriate payor through NEIC. Claims are then electronically sorted, batched, and distributed to the appropriate payor. In less than 24 hours, payers receive edited electronic claim data, ready for adjudication. Benefits of the NEIC system include paperless processing, faster turnaround time, reduction of claims backlog, and improved patient relations (NEIC, 1993).

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

During this research, the author determined how the Outpatient Third Party Collection Program has functioned at Eisenhower Army Medical Center and how it can be improved. Based on the findings of this research, principles of total quality management (process improvement), and the benchmarking process, a conceptual model was developed outlining policies and guidelines for the administration of the program. Additionally, other suggestions for the improvement of the program were included in the discussion paragraph.

Recommendations

The author recommends that this research be used by

other Army Medical Treatment Facilities as a benchmark for the development and improvement of their OTP collection programs.

The author further recommends that the conceptual model developed as a result of this research be approved by the EAMC Commander.

Because EAMC will soon be a part of the program, the author recommends that a management study be conducted to determine new manpower requirements for the OTP collection program after implementation.

Lastly, the author recommends monitoring the program's performance and feasibility as EAMC implements DoD healthcare reform initiatives in the future.

Need for Further Research

The author views the methodology developed by U.S. MEDCOM to determine manpower requirements as a weakness in this study. This methodology needs to be revised to account for the use of electronic data interchange. As EAMC begins using EDI in the future, the manpower requirements for this program should be reanalyzed. Also, job descriptions and responsibilities should also be reviewed. This process will further determine the optimal structuring of this program in the future.

Reference List

American Medical Association. 1993. Physicians' Current Procedural Terminology (Fourth Edition). Chicago: AMA

Anderson, Howard J. 1991. Are hospitals ready for more growth in ambulatory care? Hospitals. June: 32-36.

Ashby, Doug. (4 Feb 94, 15 Oct 93, 14 May 93). Third Party Line (Maximize Collections to Enhance Care). U.S. Army Medical Command.

Burns, L.A. 1991. Financial issues in ambulatory care. Topics in Health Care Financing. (17)3: 53-65.

Chenoweth, David. 1993. Healthcare claims and cost analysis can reap huge dividends for employers. Occupational Health and Safety. April: 34,83,97.

Data Watch. 1991. Tracking the long-term growth in outpatient care. Hospitals. December: 16-21.

Department of Defense Instruction Number 6010.15. 1993. Third Party Collection Program. Washington, DC: Office of the Assistant Secretary of Defense for Health Affairs.

Department of Defense. Office of the Assistant Secretary of Defense (Health Affairs). 1993. Implementing Managed Care in the Military Health Services System. Aug 25.

Davis, James B. 1992. 365 Ways to Manage the Business Called Private Practice. Chicago: Practice Management Information Corporation.

EAMC Information Management Division. 1993. Outpatient Third Party Collection Program Guide. January 1993.

Eubanks, Paula. 1992. Unwieldy claims could bog down automation process. Hospitals. July: 59-60.

Federal Register. (1992, September). 57:175, p.41096, Washington, DC: U.S. Government Printing Office.

Gatson, J. Harper. 1993. Medicine in the 21st century. Journal of MAG. (82): 181-184.

Reference List (Cont'd)

Hard, Rob. 1992. Inching toward EDI: experts look at obstacles. Hospitals. December: 42-43.

Hudson, Terese. 1993. Reform follows market, insurers, providers strengthen ties as debate continues. Hospitals. February: 28-31.

Jacobs, P. 1987. The Economics of Health and Medical Care. Maryland: Aspen.

Kongstvedt, P.R. 1989. The Managed Healthcare Handbook. Maryland: Aspen.

Lynn, Monty L. 1991. Deming's quality principles: a health care application. Hospital & Health Services Administration. 36(1): 111-119.

National Electronic Information Corporation. 1993. Acu-Claim Information Booklet. Georgia: NEIC.

Patton, Michael Q. 1990. Qualitative Evaluation and Research Methods (2nd Ed.). Newbury Park: Sage Publications.

Puckett, Craig D. 1992. The Educational Annotation of ICD-9-CM (4th Edition). Channel Publishing, Ltd.

Rizk, Kimberly H. 1992. The billing process: improving efficiency and effectiveness. Journal of Ambulatory Care Management. (15)2: 11-18.

Schaich, Robert L. 1993. Making the Case for EDI. Computers in Healthcare. December: 18-22.

Turabian, Kate L. 1987. A Manual for Writers of Term Papers, Theses and Dissertations (5th Edition). Chicago: The University of Chicago Press.

Voorhees, D. 1991. Mistakes to avoid in CPT coding and billing. Medical Laboratory Observer. (23)6: 49-50,52, 54, 56.

Weilan Systems. Copyright 1990. SimpleCase. Release 1.0.

Yin, Robert K. 1989. Case Study Research: Design and Methods. Newbury Park: Sage Publications.

APPENDIX A

OTP COLLECTION PROGRAM FLOWCHART

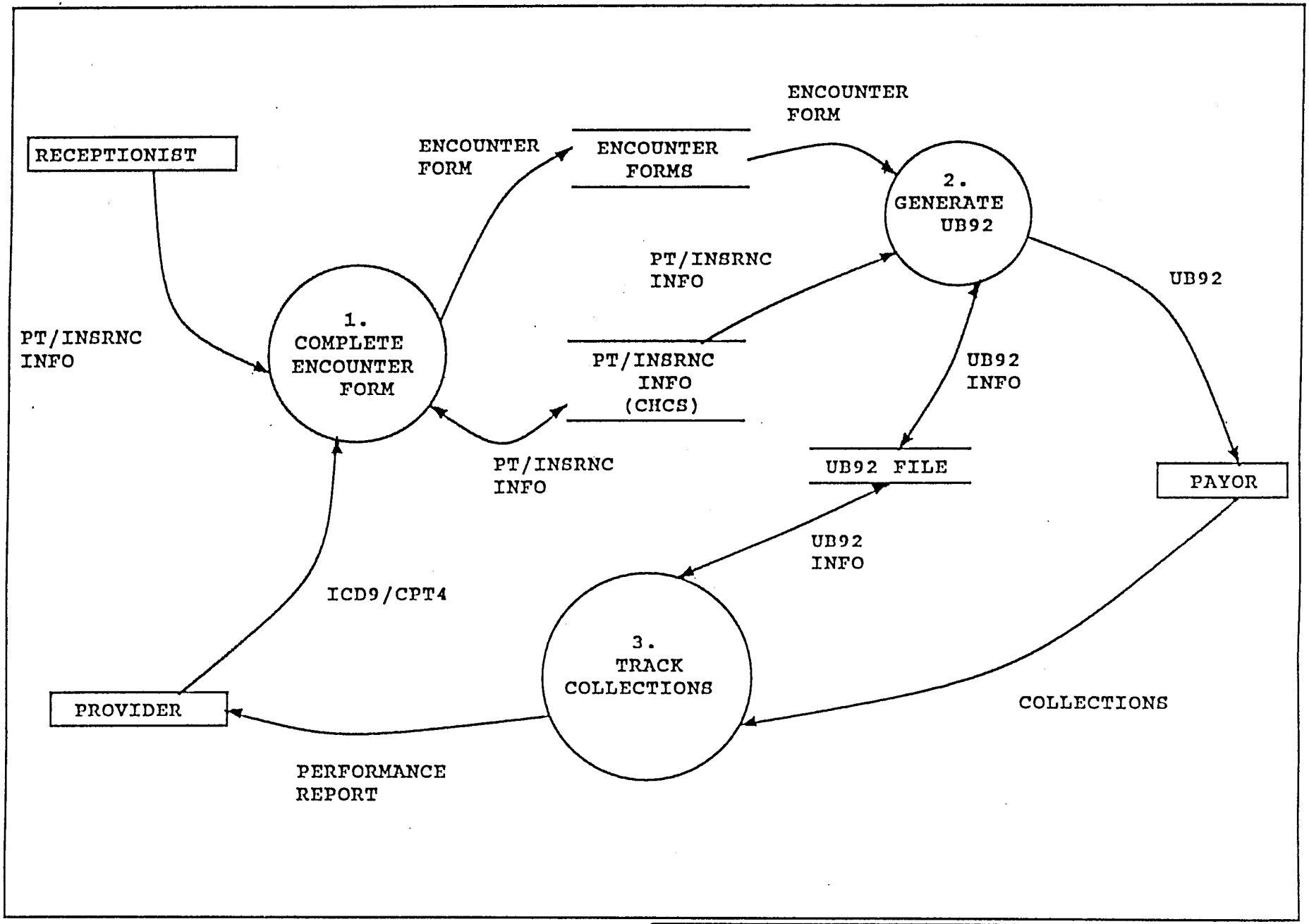


Diagram 0.
THIRD PARTY COLLECTION

APPENDIX B

FORMAT FOR RECOMMENDATIONS/ISSUES

Recommendation/Issue Sheet

EAMC OTP Collection Program

Date:_____

TO: EAMC OTP Collection Program Project Manager

From:_____

A. ISSUE: (One Sentence on the Issue or Topic)

B. BACKGROUND: (Provide a brief history on the issue or recommendation. What has occurred in the past? What has occurred that has caused this issue or recommendation? Provide other information which will clarify the issue or situation.)

C. RECOMMENDATION: (Briefly explain the solution recommended by the originator of this issue. Provide some details as to how the solution should be implemented and why this is the best solution.)

APPENDIX C

CONCEPTUAL MODEL

DEPARTMENT OF THE ARMY
HEADQUARTERS, DWIGHT DAVID EISENHOWER ARMY MEDICAL CENTER
FORT GORDON, GEORGIA 30905-5650

DDEAMC MEMORANDUM
No 40-30

Medical Services
OUTPATIENT THIRD PARTY COLLECTION PROGRAM

1. PURPOSE: To establish responsibilities and procedures for the collection of monies under the outpatient third party collection program(OTPCP) at Dwight David Eisenhower Army Medical Center(DDEAMC).

2. REFERENCES:

a. Federal Register, September 1992.

b. Department of Defense Instruction No. 6010.15, 10 March 1993.

3. GENERAL: Congress authorized the Department of Defense (DOD) hospitals the authority to collect monies from third party payors for provision of outpatient medical care services in DOD hospitals (Section 713, Public Law 101-510). DDEAMC has been delegated the responsibility to collect third party monies for treatment of its patients within the Medical Center.

4. SCOPE: This regulation applies to all outpatient services provided at DDEAMC and patients who may potentially have third party insurance.

5. RESPONSIBILITIES:

a. The Medical Center Commander is responsible for:

(1) Aggressively supporting and implementing an outpatient third party collection program at DDEAMC IAW reference b.

b. The Deputy Commander for Clinical Services is responsible for:

(1) Ensuring that the medical staff and other health care providers actively participate and support the DDEAMC OTPCP.

(2) Ensure that the medical staff is kept abreast of the OTPCP status and current issues affecting the program on a monthly basis.

(3) Ensuring that new medical staff are oriented to the importance of the OTPCP and DDEAMC policies concerning this program.

c. The Chief, Clinical Support Division is responsible for:

(1) Ensuring that clinic personnel actively participate and support the DDEAMC OTPCP.

(2) Ensuring that new clinic personnel are trained on OTPCP procedures and policies.

d. The Chief, Resource Management Division is responsible for:

(1) Monitoring all monies collected under the DDEAMC OTPCP on a monthly basis to be reported to the Commander.

(2) Providing an audit trail on how OTPCP monies are spent.

(3) Coordinating with the Chief, PAD to determine the OTPCP goals, decrement, and incentive program on an annual basis.

e. The Chief, Patient Administration Division is responsible for:

(1) The overall management of the DDEAMC OTPCP.

(2) Providing an update to the Commander and Department Chiefs in regard to the program's status on a monthly basis (see Attachment 1).

(3) Assisting departments/clinics in the education of personnel involved in the OTPCP as required.

(4) Assisting in the updating of encounter forms (Appendix B) on an annual basis.

(5) Publishing a monthly "third party line" newsletter informing DDEAMC personnel on current areas of interest in regard to the program (Attachment 3).

f. The Chief, Information Management Division is responsible for:

(1) Providing information systems support to the OTPCP:

(a) Maintain CHCS data file extract routine.

(b) Maintain OTPCP database program (in Oracle).

(2) Providing communications support -- ensuring data communications to the Billing Office (in an outbuilding).

(3) Providing printing support to the OTPCP -- reproduction of SOPs and promotional materials.

h. The Center Judge Advocate is responsible for

(1) Providing legal support to the DDEAMC OTPCP.

g. Department Chiefs are responsible for:

(1) Aggressively supporting the OTPCP.

(2) Ensuring that an encounter form is accurately completed on all patients identified as having third party insurance.

(3) Following the procedures outlined in paragraph 5, and the OTPCP process outlined at appendix D.

(4) Ensure that the patient encounter form is updated as required to reflect the most common diagnosis and procedure codes performed in the clinic.

(5) Educating all clinic personnel on the OTPCP as required to ensure that they are proficient in their respective duties and responsibilities in regard to the conduct of the program.

i. The OTPCP staff will:

(1) Collect the encounter forms from the clinics.

(2) Review the forms for completeness and accuracy for billing.

(3) Review third party information on the patient in the central computer system. Update the information as needed.

(4) Prepare the appropriate billing forms.

(5) Submit the bills for payment to the third party carrier.

(6) Initiate and maintain a payment record on the patient's visit.

(7) Notify the CJAG of delinquent accounts or problems in obtaining third party payor information from patients.

5. CLINIC PROCEDURES:

a. All clinics will post a sign stating that all patients must notify the receptionist/insurance clerk if they have health insurance. An example of this sign can be found at the internal medicine clinic.

b. All clinics will post a fact sheet on the OTPCP at the reception desk which can be easily read by patients as they check in (Attachment 5).

c. All clinics will use the guidelines at Appendix D which outline the procedures to be followed IAW the DDEAMC OTPCP.

d. Clinic receptionists/insurance clerks will update third party payment information on CHCS IAW Attachment 6.

e. Clinic receptionists/insurance clerks will interview all patients presenting for care IAW Attachment 7.

f. Clinic receptionists/insurance clerks will complete the third party collection registration form on all new patients with insurance (see Attachment 8).

g. The health care provider will at the conclusion of the clinic visit, enter the diagnosis, appropriate information about the visit, and his name onto the encounter form.

h. Clinic receptionists/insurance clerks will ensure that all encounter forms are reviewed for completeness and accuracy before they are picked up by the OTPCP staff.

i. Clinic receptionists/insurance clerks will ensure that each clinic visit is entered in CHCS to accomplish end of day processing.

6. PROCEDURES:

a. Outpatient Third Party Collection Program Process (Attachment 4).

b. Procedures for updating outpatient third party payment information (Attachment 6).

c. DDEAMC insurance questions for patient interview (Attachment 7).

DDEAMC MEMO 40-30

ATTACHMENT 1

PATIENT ADMINISTRATION DIVISION

THIRD PARTY COLLECTION PROGRAM
DEPARTMENT OF MEDICINE

AS OF : _____

CLINIC CODE CODE	CLINIC DESCRIPTION	COLLECTED FY93	COLLECTED FY94	BASE LINE
BAAA	INTERNAL MEDICINE	36,361.48	22,248.93	37,000.00
BABA	ALLERGY/IMMUNOLOGY	1,169.39	453.06	2,000.00
BACA	CARDIOLOGY	7,373.11	4,736.48	8,000.00
BAFA	ENDOCRINOLOGY	4,222.09	3,525.85	7,000.00
BAGA	GASTROENTEROLOGY	4,714.70	6,273.25	10,000.00
BAHA	HEMATOLOGY	1,187.50	1,007.50	2,000.00
BAJA	NEPHROLOGY	4,612.26	6,067.31	10,000.00
BANA	PULMONARY DISEASE	3,191.09	2,343.63	5,000.00
BAOA	RHEUMATOLOGY	3,594.27	2,881.60	5,000.00
BAPA	DERMATOLOGY	19,506.42	6,288.32	19,000.00
BAQA	INFECTIOUS DISEASE	607.50	300.00	500.00
BAMA	ONCOLOGY	13,220.20	5,319.45	13,000.00

ATTACHMENT 2

C-7

PATIENT ENCOUNTER FORM - FPC

PROVIDER:

DATE:

INSURANCE: ☐ YES ☐ NO

SMOKER: ☐ YES ☐ NO

ARR TIME:

APPT TIME:

OFFICE VISITS	NEW	ESTAB
NURSING		☐ 99211
SIMPLE	☐ 99202	☐ 99212
EXPANDED	☐ 99203	☐ 99213
DETAILED	☐ 99204	☐ 99214
COMPREHENSIVE	☐ 99205	☐ 99215

PREV. MEDICINE	NEW	ESTAB
< 1 YEAR	☐ 99381	☐ 99391
1-4 YEARS	☐ 99382	☐ 99392
5-11 YEARS	☐ 99383	☐ 99393
12-17 YEARS	☐ 99384	☐ 99394
18-39 YEARS	☐ 99385	☐ 99395
40 - 64 YEARS	☐ 99386	☐ 99396
> 64 YEARS	☐ 99387	☐ 99397

INJECTIONS/IMMUNIZATIONS

☐ BENADRYL	90782
☐ BICILLIN/ROCAPHIN	90788
☐ CORTISONE	90782
☐ DEMEROL	90782
☐ DHE	90782
☐ HORMONAL	90782
☐ VALIUM	90782
☐ B_{12}	90782
☐ dT	90718
☐ DPT	90701
☐ dTaP	90701
☐ HIB	90737
☐ HEPTAVAX	90731
☐ INFLUENZA	90724
☐ MMR	90707
☐ PNEUMOVAX	90732
☐ TB	86585
☐ POLIO/OPV	90712

GROUP COUNSELING SESSION

30 MINUTE	☐ 99411
60 MINUTE	☐ 99412

TELEPHONE COUNSELING

SIMPLE/BRIEF	☐ 99371
INTERMEDIATE	☐ 99371

DIAGNOSTIC TESTS ORDERED

LABORATORY		*RADIOLOGY*	
☐ ABG	87290	☐ ABDOMEN	74020
☐ CHEM 6	80006	☐ ANKLE	73600
☐ CHEM 12 or more	80019	☐ CHEST AP	71010
☐ CBC	85022	☐ CHEST PA/LAT	71020
☐ CHLAYMDIA	87110	☐ C SPINE	72040
☐ C&S	87085	☐ ELBOW	73115
☐ GC	87072	☐ FINGER	73140
☐ GHb/HbA1c	83036	☐ FOOT	73620
☐ GRAM STAIN	87205	☐ HAND	73120
☐ HCT	85014	☐ HIP	73500
☐ HEMOCCULT	82270	☐ KNEE	73560
☐ HCG	84702	☐ LS SPINE	72100
☐ LAE/LFTs	47399	☐ MAMMOGRAM	76091
☐ LIPID PROFILE	80061	☐ SINUS	70220
☐ MONOSPOT	86300	☐ UPPER GI SBFT	74240
☐ OB LAB SET	80055	☐ UPPER GI BARIUM	74246
☐ PAP SMEAR	88150	☐ ULTRASOUND OB	76810
☐ SED RATE	85650	☐ ULTRASOUND PELV	76856
☐ STREP SCRN	86317	☐ ULTRASOUND RUQ	76604
☐ THYROID PNL	80070	☐ OTHER	
☐ URINALYSIS	81000		
☐ OTHER			

PROCEDURES

☐ ANOSCOPY	46600	☐ PFT/SPIRO	78596	☐ PUNCH BX	11100
☐ CATHER	52005	☐ PROCTO	45300	☐ RPLS	92511
☐ CRYO/LN2	17340	☐ SLIT LAMP	92002	☐ SUTURE	15850
☐ DIAPH. FIT	57170	☐ STRESS TEST	93015	☐ VAS	55250
☐ ECG	93005	☐ TONOMETRY	92100		
☐ ENDOMT BX	58100	☐ VENIPUNCT	36415		
☐ NEBULIZER	94664				
☐ NON-STRESS	59025				
☐ O2 TX	94799				

SAME DAY SURGERY

☐ ABG	94700
☐ COLPOSCPY	57452
☐ EXCS. BX	11100
☐ FFS	45330
☐ I & D	10060
☐ JNT ASPN/INJ	20610
☐ LP	62270
☐ NAIL RML	11750
☐ NDLE ASP/BX	19100

DIAGNOSES (IF >1 PLEASE PRIORITIZE BY #)

___	795.0	Abnormal Pap Smear	___	787.0	Nausea/Vomiting
___	303.9	Alcohol Dependence	___	278.0	Obesity
___	995.3	Allergic Reaction	___	380.10	Otitis Externa
___	477.9	Allergic Rhinitis	___	382.9	Otitis Media, Acute
___	300.0	Anxiety Disorder	___	381.20	Otitis Media, Chron
___	716.9	Arthritis, Unspecified	___	789.0	Pain, Abdomen/Epigastric
___	429.2	ASCAD	___	729.5	Pain, Arm/Shoulder
___	493.9	Asthma	___	724.5	Pain, Back
___	239.3	Breast Lump	___	786.50	Pain, Chest
___	490	Bronchitis	___	729.5	Pain, Foot
___	682.9	Cellulitis	___	729.5	Pain, Hand/Wrist
___	616.0	Cervicitis	___	719.45	Pain, Hip
___	372.30	Conjunctivitis	___	719.46	Pain, Knee
___	564.0	Constipation	___	729.5	Pain, Leg
___	786.2	Cough	___	723.1	Pain, Neck
___	496	COPD	___	625.9	Pain, Pelvic, Female
___	311	Depression	___	5339	Peptic Ulcer Disease
___	250.0	Diabetes Mellitus	___	462	Pharyngitis
___	558.9	Diarrhea	___	601.0	Prostatitis
___	780.4	Dizziness	___	782.1	Rash
___	788.1	Dysuria	___	569.3	Rectal Bleeding
___	780.7.	Fatigue/Malaise	___	461.9	Sinusitis
___	780.6	Fever	___	780.50	Sleep Disorder
___	610.1	Fibrocystic Breast	___	308.00	Stress, Acute
___	558.9	Gastroenteritis	___	305.1	Tobacco Use Disorder
___	247.9	Gout	___	099.0	Urethritis
___	578.9	GI Bleed	___	599.0	UTI
___	784.0	Headache	___	626.9	Vaginal Bleeding
___	455.6	Hemorrhoids	___	616.0	Vaginitis, Unspecified
___	253.9	Hormonal Deficiency	___	079.9	Viral Syndrome/URI
___	272.4	Hyperlipidemia	___	078.1	Warts, Unspecified
___	401.9	Hypertension			
___	242.9	Hyperthyroidism	___	V25.9	Family Planning/Contraception
___	244.9	Hypothyroidism	___	V70.3	Physical (Sports/School)
___	607.84	Impotence	___	V22.2	Visit OB
___	788.3	Incontinence	___	V20.2	Visit Well Child
___	628.9	Infertility, Female	___	V72.3	Visit Well Woman
___	879.8	Laceration			
___	626.4	Menstrual Irregularities	___		
___	672.2	Menopausal Syndrome			

ATTACHMENT 3

MONTHLY NEWSLETTER/EMAIL FORMAT

I. **OUTPATIENT THIRD PARTY COLLECTIONS STATUS:**

a. Total Collections to Date vs. Baseline

b. Recognition of clinics that have performed exceptionally well during the month.

c. Recognition of key personnel performing exceptionally well during the month.

II. **PROBLEM AREAS/ISSUES NOTED DURING THE MONTH:**

a. Highlights of monthly OTPCP meeting.

III. **HIGHLIGHTS OF INCENTIVE PROGRAM MONIES USED TO ENHANCE PATIENT CARE:**

IV. **UPCOMING EDUCATIONAL PROGRAM:**

V. **REQUEST FOR FEEDBACK FROM CLINICS:**

VI. **MISCELLANEOUS**

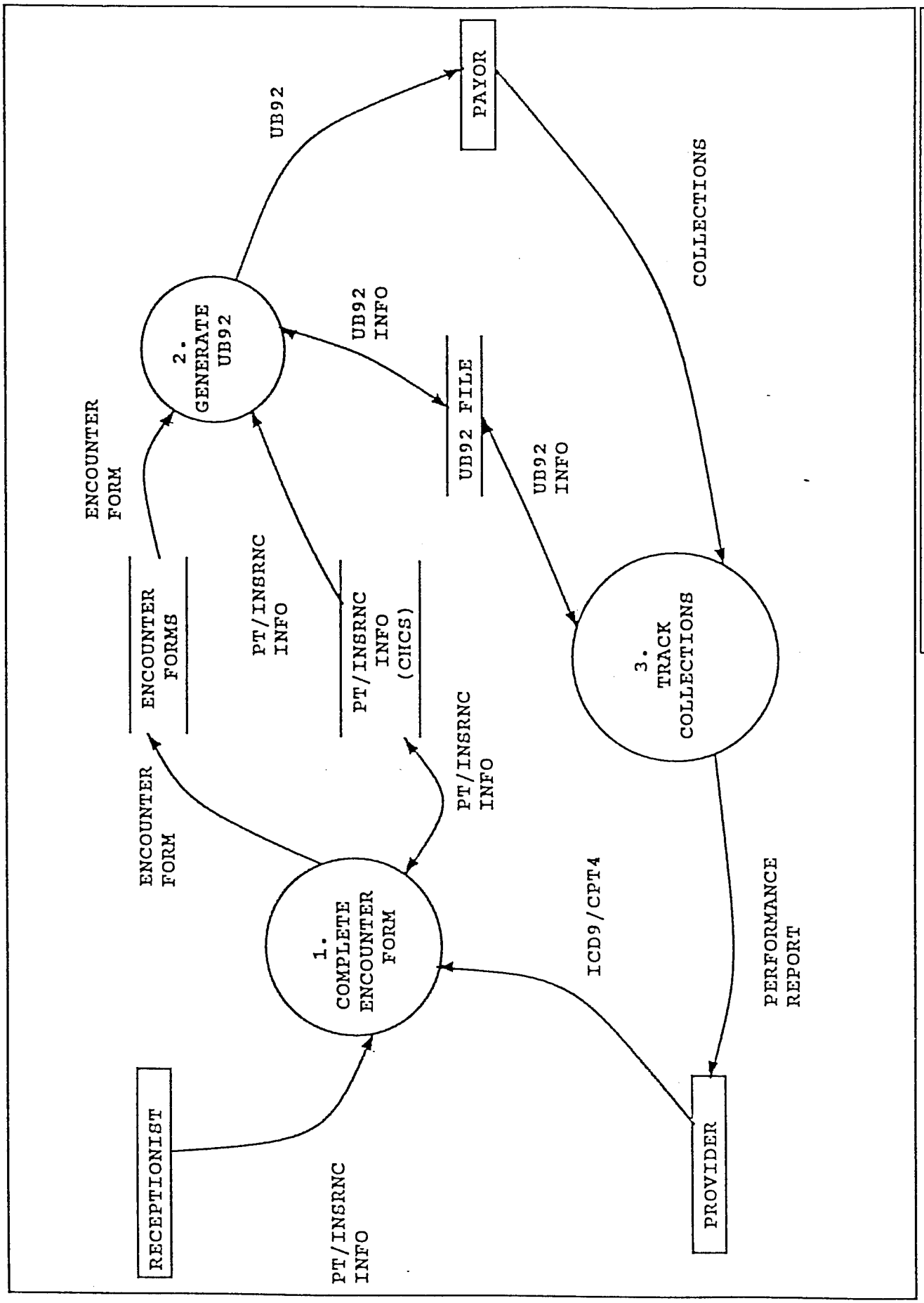


Diagram 0.
THIRD PARTY COLLECTION

IF YOU HAVE PRIVATE HEALTH INSURANCE
PLEASE LET THE RECEPTIONIST KNOW

* LIKE PRIVATE HOSPITALS, WE DEPEND ON REIMBURSEMENTS FROM INSURANCE COMPANIES TO FUND PATIENT CARE.

* UNLIKE PRIVATE HOSPITALS, YOU WILL NOT BE BILLED FOR ANY DEDUCTIBLES OR COST SHARES!

* YOU WILL MAKE IT POSSIBLE TO PURCHASE NEW EQUIPMENT AND SERVICES WHICH BENEFIT YOU.

* YOU WILL ENABLE THE PHARMACY TO CARRY A WIDER RANGE OF DRUGS.

* UNLIKE PRIVATE HOSPITALS, YOU WILL KNOW EVERY DOLLAR COLLECTED GOES DIRECTLY TOWARDS PATIENT CARE.

ATTACHMENT 6

PROCEDURES FOR UPDATING OTPCP INSURANCE INFORMATION

1. PURPOSE: To establish procedures for updating outpatient third party payment information.

2. RESPONSIBILITY:

a. Chief, Patient Administration Division is responsible for maintenance of a system for collection of third party payor information at Eisenhower Army Medical Center.

b. Chief, Clinical Support is responsible for collection, updating, and/or verification of third party payor information for patients treated in an outpatient clinic at Eisenhower Army Medical Center.

3. PROCEDURES:

a. Upon arrival of the patient in the clinic and during the check-in process, verify insurance policy information on the outpatient file by reviewing CHCS Patient Insurance Information (PII) screen with the patient.

b. Ask specific insurance questions to determine presence or absence of third party insurance (see Appendix G). This must be done upon every patient visit, even if the same patient was seen yesterday. NOTE: Never say to the patient "You don't have outside health insurance, do you?"

c. If there is a record on file and insurance information is displayed, confirm the information with the patient (see Attachment 7).

(1) Enter PII, then 1st letter of last name followed by last 4 digits of SSN, hit Return key.

(2) The screen will show general insurance information: insurance company name, policy number, effective date, expiration date, policy holder's name, relationship to policy holder and policy status.

d. If there is a record on file, insurance information is displayed and there is a change, then enter appropriate change(s) on the mask (insurance company name, individual/group coverage, policy effective date, etc.).

(1) Press Select key. A detailed insurance data screen pops up.

(2) Make changes in appropriate field(s) by moving cursor through entire mask. Then question "Do You Want To File?" will highlight. Enter 'Y' for Yes. Hit Return key.

(3) Changes will be stored and appear on both general and detailed screens.

(4) Proceed to item i.

e. If there is a record on file, no insurance information is displayed and patient indicates she/he now has insurance, add the new insurance data to the record as follows:

(1) Upon bringing up patient's record, the screen will automatically display the question, "Is The Patient Covered By Insurance?" Enter 'Y' for yes.

(2) The detailed insurance screen pops up. Move cursor through the mask and make entries in appropriate fields.

(3) Continue through entire mask. Then question "Do You Want To File?" will highlight. Enter 'Y' for yes, hit Return key.

(4) Changes will be stored and appear on both general and detailed screens.

(5) Proceed to item i.

f. If there is a record on file, no insurance information displayed, and patient indicates no insurance; the answer displayed question "Is the Patient Covered by Insurance?" with an 'N' for no. Screen automatically returns to main menu.

g. If there is no record on file, and patient indicates she/he has insurance, then new patient data as well as insurance information must be entered onto the record by using the following steps.

(1) Either add new patient data using mini-registration (MRG) option (follow current procedure) or send patient to A&D.

(2) Once patient data is entered, then add new insurance information. Bring up detailed insurance data screen (Enter PII, 1st letter of last name followed by last 4 digits of SSN. Hit Select key).

(3) Make changes in appropriate fields by moving cursor through the mask and entering data.

(4) Continue through entire mask, then enter 'Y' to file question.

(5) Proceed to item i.

h. EAMC Form 688. To add a new insurance company, some clinics may elect to additionally use optional form EAMC Form 688 (Third Party Collection Registration Form) (Appendix C) to collect insurance information for later entry onto PII screen.

(1) It is imperative if you use this form that you verify its completeness -- mandatory fields are "Name/FMP/SSN/DOB" stamp, "Today's Date", "Clinic" name, "Name of Insurance Co", "Policy Number" (of insured -- not necessarily the patient), "Insured's Name on Card" and "Signature".

(2) Receptionist should complete this form (not the patient) entering responses from the patient, for legibility of information for data entry later and for accuracy of information.

i. If insurance data cannot be verified (e.g. individual has insurance but does not have policy number or insurance card, or patient refuses to disclose information, etc.) write note on encounter form margin so OTPCP can follow up with phone call to patient at a later date.

j. When looking at insurance card, look for a phone number (1-800 or other) on the card. Copy this phone number in margin of encounter form. It will expedite claims processing follow up by OTPCP staff, if needed.

ATTACHMENT 7

DDEAMC INSURANCE QUESTIONS FOR PATIENT INTERVIEW

1. If patient has a record on CHCS file and record shows previous insurance, then ask:

- Do you still have insurance with _____?

- If Yes, no need to ask further questions.

- If No, then continue.

2. If patient has no record on CHCS file, then ask the standard questions to complete the file record. Enter the information directly onto the file or on the optional Third Party Collection form. Then continue.

FOR RETIREE OR FAMILY MEMBER:

1. Slowly ask: Do you or your spouse have health insurance through an employer or another family member or as a supplement to CHAMPUS or MEDICARE? (Adjust question based on visual age of patient). (If patient is unsure what you are asking, explain in more detail).

- If Yes, ask to see insurance card and enter employer information and other appropriate entries onto file.

- If No, no further questions.

Addressograph NAME/FMP/SSN/DOB

THIRD-PARTY COLLECTION REGISTRATION FORM

TODAY'S DATE _____ CLINIC _____ CLERK _____

PATIENT ADDRESS _____ SEX M - F WORK PHONE _____

_____ HOME PHONE _____

****

ARE YOU COVERED UNDER ANY HEALTH INSURANCE POLICY? (EXCLUDING CHAMPUS, MEDICAID BUT INCLUDING MEDICARE?) CIRCLE ONE, IF YES GO TO NEXT SECTION, IF NO PLEASE SIGN AT THE BOTTOM.

****

INSURANCE PLAN #1

NAME OF INSURANCE CO _____ POLICY NUMBER _____

INS CLAIM ADDRESS ON CARD _____

_____

GROUP NUMBER (if applicable) _____

INSURED'S NAME ON CARD _____

PATIENT RELATION TO INSURED ? SELF SPOUSE CHILD

IS THIS THROUGH AN EMPLOYER? YES NO EMPLOYER'S NAME _____

EMPLOYER ADDRESS: _____

_____

****

INSURANCE PLAN #2

NAME OF INSURANCE CO _____ POLICY NUMBER _____

INS CLAIM ADDRESS ON CARD _____

_____

GROUP NUMBER (if applicable) _____

INSURED'S NAME ON CARD _____

PATIENT RELATION TO INSURED ? SELF SPOUSE CHILD

IS THIS THROUGH AN EMPLOYER? YES NO EMPLOYER'S NAME _____

EMPLOYER ADDRESS: _____

_____

****

I certify that the above information is true to the best of my knowledge. Falsification of information is covered by 18 U.S. Code, section 1001 which provides for a maximum fine of $10,000 or imprisonment for five years, or both. I hereby authorize and request that the proceeds of any and all benefits be paid directly to the facility of the uniformed service for hospitalization or outpatient services provided me and/or my dependents.

SIGNATURE _____ DATE _____

PRIVACY ACT STATEMENT

AUTHORITY: TITLE 10 USC, SECTION 1095 AND EO 9397. PRINCIPAL PURPOSE(S): INFORMATION WILL BE USED TO COLLECT FROM PRIVATE INSURERS FOR CARE PROVIDED TO MILITARY BENEFICIARIES. SUCH MONETARY BENEFIT ACCRUING TO THE MILITARY MEDICAL FACILITY WILL BE USED TO ENHANCE HEALTH CARE DELIVERY IN THE MEDICAL TREATMENT FACILITY. ROUTINE USE(S): THE INFORMATION ON THIS FORM WILL BE RELEASED ONLY TO YOUR INSURANCE COMPANY DISCLOSURE: VOLUNTARY; HOWEVER, A FAILURE TO PROVIDE COMPLETE AND ACCURATE INFORMATION MAY RESULT IN DISQUALIFICATION FOR HEALTH CARE SERVICES FROM FACILITIES OF THE UNIFORMED SERVICES.

APPENDIX D

INCENTIVE PROGRAM BASELINES

DEPARTMENT OF SURGERY

CLINIC CODE	CLINIC DESCRIPTION	COLLECTED FY93	BASE LINE
BBAA	GENERAL SURGERY	$41,532.03	$40,000.00
BBBA	CARDIO-VASC/THORAC	$1,758.01	$2,000.00
BBBB	PERIPHERAL VASC	$12,744.09	$12,000.00
BBCA	NEUROSURGERY	$2,366.00	$2,000.00
BBDA	OPTHALMOLOGY	$15,010.94	$15,000.00
BBFA	OTORHINO-LARYNGOLOGY	$7,207.07	$7,000.00
BBGA	PLASTIC SURG	$5,180.23	$4,000.00
BBIA	UROLOGY	$45,315.89	$45,000.00
BEAA	OTRHOPAEDIC	$15,296.22	$17,000.00
BEBA	CAST CLINIC	$728.00	$2,000.00
BEFA	PODIATRY	$7,686.70	$8,000.00

DEPARTMENT OF MEDICINE

CLINIC CODE	CLINIC DESCRIPTION	COLLECTED FY 93	BASE LINE
BAAA	INTERNAL MED	$36,361.48	$37,000.00
BABA	ALLERGY/ IMMUNOLOGY	$1,169.39	$2,000.00
BACA	CARDIOLOGY	$7,373.11	$8,000.00
BAFA	ENDOCRINOLOGY	$4,222.09	$7,000.00
BAGA	GASTROENTEROL	$4,714.70	$10,000.00
BAHA	HEMATOLOGY	$1,187.50	$2,000.00
BAJA	NEPHROLOGY	$4,612.26	$10,000.00
BANA	PULMONARY	$3,192.09	$5,000.00
BAOA	RHEUMATOLOGY	$3,594.27	$5,000.00
BAPA	DERMATOLOGY	$19,506.42	$19,000.00
BAQA	INFECTIOUS DISEASE	$607.50	$500.00
BAMA	ONCOLOGY	$13,220.20	$13,000.00

DEPT OF PEDS/FAM PRAC/ER MED/OB-GYN

CLINIC CODE	CLINIC DESCRIPTION	COLLECTED FY93	BASE LINE
BDAA	PEDIATRICS	$2,370.00	$2.000.00
BDBA	ADOLESCENT	$1,570.45	$1,000.00
BGAA	FAMILY PRACTICE	$163,031.40	$155,000.00
BIAA	EMERGENCY MEDICINE	$69,897.91	$70,000.00
BCBA	GYNECOLOGY	$15,837.26	$16,000.00
BCCA	OBSTETRICS	$1,640.76	$2,000.00

ALL OTHER CLINICS

CLINIC CODE	CLINIC DESCRIPTION	COLLECTED FY93	BASE LINE
BAKA	NEUROLOGY	$9,316.84	$9,000.00
BALA	NUTRITION CARE		$12,000.00
DGBA	HEMODIALYSIS	$503.44	$50,000.00
BFAA	PSYCHIATRY	$10,081.52	$10,000.00
BFBA	PSYCHOLOGY	$1,868.88	$2,000.00
BFCA	CHILD GUIDANCE	$1,134.44	$2,000.00
BFDA	MENTAL HEALTH	$200.00	$1,000.00
SSSS	SUPPLEMENTAL CARE	$18,863.31	$20,000.00

APPENDIX E

SUGGESTED STYLE FOR STICKERS ADVERTISING PROGRAM

SUGGESTED STYLE FOR STICKERS ADVERTISING

OTP COLLECTION PROGRAM

THIS ITEM WAS PURCHASED USING
FUNDS RECOVERED BY THE
EISENHOWER ARMY MEDICAL CENTER
THIRD PARTY COLLECTION PROGRAM

Suggested Colors: White Background with Burgundy Letters

Suggested Size: 1 1/2" x 3"

APPENDIX F

FREQUENTLY ASKED QUESTIONS

Frequently Asked Health Insurance Questions

EAMC OTP Collection Program

1. Healthcare is my service benefit. Why does Eisenhower Army Medical Center have to bill my insurance company?

Quality health care is very expensive, and cost are constantly rising. Your health care is paid for by your federal tax dollars. The law requires EAMC to recover these costs if they are covered by insurance.

2. What effect will this have on my health insurance?

Health insurance is intended to cover your medical service needs included in your policy and the premiums you pay for those services. Since you are using that policy to allow EAMC to recover the cost of providing you with health care, the insurance is being used as it was intended. Therefore, your insurance will not be significantly affected.

3. If the full cost of care is not recovered, will I get a bill from EAMC or my insurance company?

No. You will not be billed for any costs that EAMC cannot recover. Federal tax dollars will pay the difference.

4. When I receive care from EAMC, will I have to pay my policy deductible?

No. EAMC will pay the deductible. This may even satisfy your policy deductible if you wish to seek private medical care in the future.

5. Where does the money go?

Payments from your insurance company for health care go into the EAMC treasury. This money is then used to enhance the quality of medical care provided at EAMC.

FOR MORE INFORMATION, CALL THE INSURANCE COORDINATOR AT (706) 791-5912

APPENDIX G

DEFINITIONS

Definitions

Billing: An itemized account of subscriber dues owed to a play by a group or subscriber; an itemized account of services rendered by a physician or supplier.

Copayment: A type of cost sharing whereby insured or covered persons pay a specified flat amount per unit of service or unit of time and their insurere pays the rest of the cost.

CHAMPUS(Civilian Health and Medical Program of the Uniformed Service): A program administered by the Department of Defense, which pays for care delivered by civilian health care providers to retired members, and dependents of active and retired members, or the seven uniformed services of the United States.

CHAMPUS Supplemental Plan: An insurance, medical service, or health plan used exclusively for supplementing an eligible person's benefit under CHAMPUS. No insurance, medical service, or health plan provided by an employer or employer group may quality as a CHAMPUS supplemental plan.

Claim: A request for payment for benefits received or services rendered.

Deductible: An amount the insured person must pay before payments for covered services begin.

Indemnity: Benefits paid in a predetermined amount in the event of a covered loss.

Insurance, Medical Service, or Health Plan: Any plan or program designed to provide compensation or coverage for expenses incurred by a beneficiary for health of medical services and supplies.

Medicare: The federal government's hospital and medical insurance program for the aged, totally disabled, and those with end-stage renal disease.

Medicare Supplemental Insurance Plan: An insurance, medical service, or health plan used exclusively for supplementing and eligible person's benefit under Medicare.

Outpatient Hospital Care: Visits to a separately organized clinic or specialty service by patients not currently admitted to the Military Treatment Facility. The patient receives healthcare services for an actual or potential disease or injury.

DEFINITIONS (CONT'D)

Premium: The amount of money the insured person (and/or the insured person's employer) pays the insurance company for enrollment in an insurance plan.

Primary Care: The point when the patient first seeks assitance from the medical care system and the care of the simpler and more common illnesses. The primary care provider usually also assumes ongoing responsibility for the patient in both health maintenance and therapy of illnes.

Third Party Payer: An entity that provides an insurance, medical service, or health plan either by contract or agreement. Third party payers include:

(a) State and local governments providing such plans.

(b) Insurance underwriters and private employers offering self-insured, partially self-insured, or partially underwritten health insurance plans.